SHBP
State Health Benefit Plan

STATE HEALTH BENEFIT PLAN (SHBP)
2013 ACTIVE EMPLOYEE
NON-TOBACCO USERS AFFIDAVIT FORM

Policyholder/Plan Member Name:_____

Social Security Number:_____

Health Plan Option: (Circle One) Cigna Standard HDHP, Cigna Wellness HDHP, Cigna Standard HMO, Cigna Wellness HMO, Cigna Standard HRA, Cigna Wellness HRA, UHC Standard HDHP, UHC Wellness HDHP, UHC Standard HMO, UHC Wellness HMO, UHC Standard HRA, UHC Wellness HRA

Check both of the following:

☐ I hereby certify that all covered members have not used any tobacco products within the last 60 days. In addition, I have attached confirmation of completion of the online health assessment and Certificate of Completion confirming that all covered members that previously used tobacco products have completed the wellness coaching program requirements as outlined in the 2013 Active Employee Non-Tobacco Users Cessation Policy.

☐ I understand that this document must be completed, both boxes checked and returned to my payroll location benefit coordinator, who will complete the required deduction information and submit to SHBP for processing. In addition, if I or any covered dependents resume using any tobacco products, I will notify SHBP immediately in writing. I acknowledge that SHBP will not refund any previously paid health premiums or surcharges.

I do hereby attest that the above information is true and correct to the best of my knowledge. I further acknowledge and understand that I may be subject to a fine of not more that $1000 or imprisonment for not less than one and no more than five years, or both if I knowingly and willfully make a false or fraudulent statement or representation to the Georgia Department of Community Health regarding information reported on this form or other information or other information pursuant to O.C.G.A. Section 16-10-20.

Signature_____ **Date** _____

Note: Once you have read and signed this Affidavit Form you must submit it to your payroll location benefit coordinator, who will complete the required deduction information and submit to SHBP for processing. If this Affidavit Form is received without a signature, all boxes checked and the necessary certificate(s) of completion and confirmation(s) of completion it will be returned to your payroll location and will delay processing.

Department/School System Use Only		
Payroll Location #	**Date of first deduction**	**Deduction Amount**